STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155426	A. BUILDING 01 B. WING	09/06/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL OAKS HEALTH CARE AND REHABILITATION CENTER	3500 MAPLE AVE TERRE HAUTE, IN47804

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K0000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 09/06/11 Facility Number: 000513 Provider Number: 155426 AIM Number: 100275360 Surveyor: Bridget Brown, Life Safety Code Specialist At this Life Safety Code survey, Royal Oaks Health Care and Rehabilitation Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type III (211)	K0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, resident rooms and spaces open to the corridors. The facility has the capacity for 213 and had a census of 190 at the time of this survey. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 09/09/11. The facility was found not in compliance with the aforementioned requirements as evidenced by:			
K0025 SS=E	Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 Based on observation and interview, the facility failed to ensure the storage room ceiling smoke barrier for 1 of 15 smoke compartments, was continuously maintained for a fire resistance	K0025	I. There were not any residents or staff found to have been affected by this practice.II. In order for residents and staff not to be affected by this practice the missing ceiling tile in the 800 Storage room ceiling has been installed. Drywall has been	10/06/2011

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	rating of 1/2 hour. LSC 8.3.2 requires smoke barriers to extend from an outside wall to an outside wall. Such barriers shall be continuous through all concealed spaces, such as those found above a ceiling, including interstitial spaces. This deficient practice affects occupants in north center smoke compartment where 10 residents were observed. Findings include: Based on observation with the maintenance director on 09/06/11 at 3:05 p.m., one panel of the suspended ceiling was missing from the 800 hall records storage room. Evidence of water damage included staining and blackened areas. The drywall had broken open leaving gaps into the attic above. The maintenance director said at the time of observation, he had not been made aware of the damage and agreed it need to be repaired. 3.1-19(b)		replaced where evidence of water damage including staining and blackened areas existed. Drywall has been replaced that had broken leaving gaps into the attic above. All above repairs were completed in order to maintain smoke barriers with at least a one half hour fire resistance rating.III. Smoke barriers with at least a one half hour fire resistance rating will be checked monthly by the Director of Maintenance to ensure that the deficient practice does not occur.IV. Director of maintenance is responsible to validate condition of smoke barriers. Director of Maintenance will report validation monthly at facility PI meeting.	

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K0029 SS=E	One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 1. Based on observation and interview, the facility failed to provide an automatic closer for the door providing access to 1 of 26 hazardous areas such as a combustible materials storage room larger than 50 square feet. Sprinklered hazardous areas are required to be equipped with self closing doors or with doors which close automatically upon activation of the fire alarm system. This deficient practice could affect visitors, staff and 6 or more residents in the north activity room smoke compartment. Findings include: Based on observation with the maintenance director on 09/06/11 at 3:30 p.m., the door separating the north activity room from the	K0029	I. There were not any residents or staff found to have been affected by this practice.II. a)In order for residents and staff not to be affected by this practice the facility installed an automatic closer on the North Activity room door which is providing access to a room larger that 50 square feet. b) Door latch separating the electrical room housing the emergency generator transfer switch and high voltage electrical panels and the kitchen area has been adjusted for proper closure.III. All automatic and self closure doors will be inspected monthly to ensure proper closure by the Director of Maintenanc to ensure that the deficient practice does not occur.IV. Director of maintenance is responsible to inspect all self closing and automatic closures upon activation of the fire alarm system to ensure compliance throughout center. Director of Maintenance will report validation monthly at facility PI meeting.	10/06/2011

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	exit corridor had no self closing device. The room was used for storing 12 wheel chairs, a bed, two club chairs and other miscellaneous furniture and equipment. The maintenance director said at the time of observation, the room was larger than 50 square feet and meant to be used for activities. There were two long tables set up with chairs to accommodate activities. The maintenance director also said he had asked repeatedly that any equipment and other items not be stored in the room. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure the door providing access to 1 of 26 hazardous areas such as a kitchen or electrical room would latch into the door frame. Sprinklered hazardous areas are required to be equipped with self closing doors that latch. This deficient practice could affect 4 kitchen staff. Findings include:			

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	Based on observation with the maintenance director on 09/02/11 at 2:20 p.m., the door separating the electrical room housing the emergency generator transfer switch and high voltage electrical panels and kitchen was closed. The door was pushed open without turning the door knob to disengage the latch. The maintenance director rechecked the door twice and agreed at the time of observation, the door latch needed repair to hold it securely closed. 3.1-19(b)			
K0061 SS=F	Required automatic sprinkler systems have valves supervised so that at least a local alarm will sound when the valves are closed. NFPA 72, 9.7.2.1 Based on observation and interview, the facility failed to ensure 1 of 1 automatic sprinkler system post indicator valves was supervised. NFPA 101, 9.7.2.1 requires supervisory attachments shall be installed and monitored	K0061	I. There were not any residents or staff found to have been affected by this practice.II. In order for residents and staff not to be affected by this practice SafeCare Incorporated is scheduled to install an electronic supervisory signal system on the Post Indicator Valve (PIV). Scheduled completion date is	10/06/2011

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	for integrity and a distinctive supervisory signal shall be provided to indicate a condition which would impair the satisfactory operation of the sprinkler system. Monitoring shall include control valves such as the post indicator valve. This deficient practice could affect all occupants. Findings include: Based on observation with the maintenance director on 09/06/11 at 1:30 p.m., the post indicator valve (PIV), a control valve for the automatic sprinkler system was located in front of the facility. The PIV was chained but there was no evidence of any electronic supervision. The maintenance director said at the time of observation, he thought it was supervised, but agreed there was no supervisory device. 3.1-(19)b		September 30, 2011. The Supervisory attachment will monitor for integrity and has a distinctive supervisory signal provided to indicate a condition which could impair the satisfactory operation of the sprinkler system.III. Electronic Supervisory System will be inspected annually by an outside contractor to ensure proper continued operation.IV. The maintenance department will retain written proof of the annual inspections by an outside contractor.	

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K0062 SS=E	Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 Based on observation and interview, the facility failed to ensure 2 of 2 sprinkler heads providing protection for the 800 hall storage room were periodically inspected and maintained. This deficient practice could affect staff, visitors and 15 residents on the 800 hall. Findings include: Based on observation with the maintenance director on 09/06/11 at 3:00 p.m., sprinkler head escutcheons were missing from two sprinklers in the 800 hall storage room leaving a gaps into the space above the suspended ceiling of 1/4 to 1/2 inch. The maintenance director said at the time of observation, he was unaware the escutcheons were missing. 3.1-19(b)	K0062	I. There were not any residents or staff found tohave been affected by this practice.II. In order for residents and staff not to be affected by this practice the two (2) escutcheons that were missing on the sprinkler heads located in the 800 hall storage have been installed.III. Sprinkler heads are inspected annually by an outside contractor for proper placement and condition of equipment. Director of Maintenance will validate quarterly proper condition of sprinkler heads to ensure that the deficient practice does not occur.IV. Director of Maintenance is responsible to maintain proper condition of sprinkler heads within the facility. Director of Maintenance will report validation quarterly at facility PI meeting.	10/06/2011

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K0067 SS=F	Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 Based on record review and interview, the facility failed to ensure 10 of 16 dampers in smoke barrier ductwork was provided necessary maintenance at least every four years in accordance with NFPA 90A. LSC 19.5.2.1 refers to Section 9.2. LSC 9.2.1 requires air conditioning, heating, ventilating ductwork and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems. NFPA 90A, 1999 Edition, 3.4.7, Maintenance, requires at least every 4 years, fusible links (where applicable) shall be removed; all dampers shall be operated to verify they fully close; the latch, if provided, shall be checked, and moving parts shall be lubricated as necessary. This deficient practice affects visitors, staff and 159 residents on the 200, 300, 400, 500, 600, and 700	K0067	I. There was not any residents or staff found to have been affected by this practice.II. In order for residents and staff not to be affected by this practice, all smoke dampers were inspected September 12th & 13th, 2011 by an outside contractor.III. Following the results of the inspection all smoke dampers affected are scheduled to be repaired and/or replaced by SafeCare, Inc. and will be operational and verified they fully close:the latch, if provided, has been checked and moving parts have been lubricated as necessary.IV. Inspections will be performed every 4(four) years as required. Director of maintenance is responsible to ensure and validate that any repairs that arise from any inspection are completed in a timely manner in order to ensure ongoing compliance. Any concerns will immediately be reported to the Administrator.	10/06/2011

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	halls and 800 halls. Findings include: Based on review of fire system inspection and test records with the maintenance director on 09/06/11 at 11:35 a.m., a smoke damper inspection test record was not provided. The maintenance director said at the time of record review, the dampers had been inspected and provided an invoice dated 11/20/09 but he had no record of the test results. He called the fire system contractor immediately and received a copy of a handwritten inspection which revealed 10 dampers failed the inspection: by the 800 hall unit manager's office "no good", the 700 hall, "2 no operation, 1 No power", and 600 hall "2 no operation". For the 200, 300, 400 and 500 halls, each equipped with two smoke dampers, the report noted "1 no operation" for each hall. The maintenance director said he did not know, but assumed repairs were made. He could find no record and called the fire system contractor again and confirmed they had performed			

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	no work on the dampers. They did not do that kind of work. The maintenance director then conferred immediately with his regional maintenance supervisor who said he should have the work done immediately. 3.1-19(b)			
K0068 SS=E	Combustion and ventilation air for boiler, incinerator and heater rooms is taken from and discharged to the outside air. 19.5.2.2 Based on observation and interview, the facility failed to ensure 1 of 15 water heater rooms were provided with intake combustion air from the outside for rooms containing fuel fired equipment. This deficient practice could create an atmosphere rich with carbon monoxide which could cause physical problems for visitors, staff and 14 residents on the 900 hall. Findings include: Based on observation with the maintenance director on 09/06/11 at 3:10 p.m., the room for the gas fuel fired water heater on the 900 hall had a single duct for air	K0068	I. There was not any residents or staff found to have been affected by this practice.II. In order for residents and staff not to be affected by this practice, the 900 hall water heater room was inspected by an outside contractor on September 16, 2011.III. Following the results of the inspection the facility is in compliance with NFPA 10119.5.2.2 Combustion and ventilation air for heater room is taken from and discharged to the outside air. The 900 hall water heater room is provided with intake combustion air from the outside for the room containing fuel fired equipment.IV.	10/06/2011

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	intake/exhaust. The duct ran from 12 inches off the floor and out the roof. An elbow in the duct left a six inch opening into the room 18 inches from the ceiling. The maintenance director said at the time of observation, it looked as though the duct was supposed to serve as a fresh air intake and exhaust and couldn't work the way it was arranged. 3.1-19(b)			